

		FOR OFF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0024265</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Knox Estates</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/01</u> to <u>06/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>PO Box 706</u> <u>Streator</u> <u>61364</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>LaSalle</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Jeffrey M. Dean</u>																									
Telephone Number: <u>815 673-5574</u> Fax # <u>815 673-1714</u>		(Title) <u>Executive Director</u>																									
IDPA ID Number: <u>36-2558089-042</u>		(Signed) _____ (Date) _____																									
Date of Initial License for Current Owners: <u>10/05/80</u>		Paid Preparer (Print Name <u>D. Kevin Mason</u> and Title) <u>Owner</u> (Firm Name <u>Mason & Associates</u> & Address) <u>1001 Shooting Park Road, Suite 105B, Peru, IL 61354</u> (Telephone) <u>815 223-8808</u> Fax # <u>815 220-3529</u>																									
Type of Ownership: <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code <u>Sec.501(c)(3)</u>																											
In the event there are further questions about this report, please contact Name: <u>Jeffrey M. Dean</u> Telephone Number: <u>815 673-5574</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Knox Estates# 0024265 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,531</u>			<u>5,531</u>	13
14	TOTALS	<u>5,531</u>			<u>5,531</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.71%

D. How many bed-hold days during this year were paid by Public Aid?

309 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location

Date started 01/05/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 1980 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: EXEMPT Fiscal Year: 06/30

* All facilities other than governmental must report on the accrual basis

STATE OF ILLINOIS

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Facility Name & ID Number Knox Estates # 0024265 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	38,964	2,379	2,379	43,722		43,722		43,722		1
2	Food Purchase		34,248		34,248		34,248		34,248		2
3	Housekeeping	7,801	2,842		10,643		10,643		10,643		3
4	Laundry		2,595		2,595		2,595		2,595		4
5	Heat and Other Utilities			19,532	19,532		19,532	(920)	18,612		5
6	Maintenance	6,042	12,930		18,972		18,972		18,972		6
7	Other (specify):*										7
8	TOTAL General Services	52,807	54,994	21,911	129,712		129,712	(920)	128,792		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	254,013	20,611	510	275,134		275,134		275,134		10
10a	Therapy			2,075	2,075		2,075		2,075		10a
11	Activities		3,803	495	4,298		4,298		4,298		11
12	Social Services	2,221		124	2,345		2,345		2,345		12
13	Nurse Aide Training	1,639			1,639		1,639		1,639		13
14	Program Transportation		9,595		9,595		9,595		9,595		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	257,873	34,009	3,204	295,086		295,086		295,086		16
	C. General Administration										
17	Administrative							36,705	36,705		17
18	Directors Fees										18
19	Professional Services			1,290	1,290		1,290		1,290		19
20	Dues, Fees, Subscriptions & Promotion			868	868		868		868		20
21	Clerical & General Office Expense		929		929		929		929		21
22	Employee Benefits & Payroll Tax			81,381	81,381		81,381		81,381		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,676	1,676		1,676		1,676		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			1,913	1,913		1,913		1,913		26
27	Other (specify):*										27
28	TOTAL General Administration		929	87,128	88,057		88,057	36,705	124,762		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	310,680	89,932	112,243	512,855		512,855	35,785	548,640		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **Knox Estates**

#0024265

Report Period Beginning:

07/01/01

Ending:

06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,643	9,643		9,643		9,643			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle											35
36	Other (specify): ^a											36
37	TOTAL Ownership			9,643	9,643		9,643		9,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			37,628	37,628		37,628		37,628			42
43	Other (specify): ^a											43
44	TOTAL Special Cost Centers			37,628	37,628		37,628		37,628			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	310,680	89,932	159,514	560,126		560,126	35,785	595,911			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(920)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotion				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (920)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	36,705		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 36,705		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 35,785		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			\$		38
39						39
40	Gift and Coffee Shop					40
41	Barber and Beauty Shop					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Knox Estates

ID# 0024265

Report Period Beginning: 07/01/01

Ending: 06/30/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox Estates

0024265

Report Period Beginning:

07/01/01

Ending:

06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(920)	0	0	0	0	0	0	0	0	0	0	(920)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(920)	0	0	0	0	0	0	0	0	0	0	(920)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	36,705	0	0	0	0	0	0	0	0	0	36,705	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	36,705	0	0	0	0	0	0	0	0	0	36,705	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(920)	36,705	0	0	0	0	0	0	0	0	0	35,785	29

Summary B

06/30/02

[illegible]

Facility Name & ID Number Knox Estates

0024265

Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Streator Unlimited, Inc.	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17	Management and Genera	\$	Streator Unlimited, Inc.	100.00%	\$ 36,705	\$ 36,705	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 36,705	\$ * 36,705	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Knox Estates # 0024265 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Knox Estates # 0024265 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Streator Unlimited, Inc.
 Street Address 305 N. Sterling St.
 City / State / Zip Code Streator, IL 61364
 Phone Number (815 673-5574
 Fax Number (815 673-1714

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Allowable administrative cost:	Clients/Days served	41,714	5	\$ 262,180	\$ 132,041	5,840	\$ 36,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 262,180	\$ 132,041		\$ 36,705	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	\$	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	3																			
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	7																			
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	1997	8	<table border="1"> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATIONS</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2001	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATIONS	\$	16
FOR OHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2001	\$			13																		
14	PLUS APPEAL COST FROM LINE 5	\$			14																		
15	LESS REFUND FROM LINE 6	\$			15																		
16	AMOUNT TO USE FOR RATE CALCULATIONS	\$	16																				
	1998	9																					
	1999	10																					
	2000	11																					
	2001	12																					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Knox Estates	COUNTY	LaSalle
---------------	--------------	--------	---------

FACILITY IDPH LICENSE NUMBER 0024265

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Knox Estates

0024265 Report Period Beginning:

07/01/01 Ending:

06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,004 B. General Construction Type: Exterior Brick veneer Frame Wood Number of Stories 1C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential	211,540	1976	\$ 26,838	1
2	Idle	229,115		6,232	2
3	TOTALS	440,655		\$ 33,070	3

Facility Name & ID Number Knox Estates

0024265

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1980	1980	\$ 347,142	\$		\$	\$	\$ 347,142
5									
6									
7									
8									
Improvement Type**									
9	Asphalt road	1986		488	24	20	24		396
10	Conness Bros.	1986		2,229	112	20	112		1,840
11	Electrical	1987		10,483	524	20	524		8,664
12	Tiling	1987		828	42	20	42		662
13	Addition	1992		6,623		10			6,623
14	Soil boring & percolation testing	1994		1,252	83	15	83		702
15	Sewer tile and leach field removal & replacement	1995		26,909	1,794	15	1,794		13,439
16	Flooring	1996		1,083	108	10	108		702
17	Floor tile and molding	2001		2,110	84	20	84		84
18	Roof	2001		30,600	1,091	20	1,091		1,091
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 429,747	\$ 3,862		\$ 3,862	\$	\$ 381,345		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 29,405	\$ 4,989	\$ 4,989	\$	5 & 7 yrs	\$ 14,222	71
72	Current Year Purchases	9,154	792	792		5 & 7 yrs	792	72
73	Fully Depreciated Assets	114,412					114,412	73
74								74
75	TOTALS	\$ 152,971	\$ 5,781	\$ 5,781	\$		\$ 129,426	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 615,788	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,643	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,643	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 510,771	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1990 van	\$ 8,371	\$	\$ 8,371	86
87	1994 van	14,802		14,802	87
88	1995 Dodge Ram van	5,123		5,123	88
89	1996 Dodge Ram van	29,580		29,580	89
90					90
91	TOTALS	\$ 57,876	\$	\$ 57,876	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2003 \$ _____

13. _____/2004 \$ _____

14. _____/2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>96</u>
		HOURS PER AIDE <u>50</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		45		45
3	Classroom Wages (a)		358		358
4	Clinical Wages (b)		686		686
5	In-House Trainer Wage (c)		595		595
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,684	\$	\$ 1,684
10	SUM OF line 9, col. 1 and 2 (c)	\$	1,684		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.

(c) For in-house training programs only. Do not include fringe benefit.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 189,660	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	175,131	419,107	3
4	Supply Inventory (priced at <u>cost</u>)		45,873	4
5	Short-Term Investments			5
6	Prepaid Insurance		21,630	6
7	Other Prepaid Expenses		10,353	7
8	Accounts Receivable (owners or related parties)		29,254	8
9	Other(specify): <u>Bond Reserve Accounts</u>		274,036	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 175,131	\$ 989,913	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		52,890	12
13	Land	33,070	89,020	13
14	Buildings, at Historical Cost	429,747	1,674,895	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	210,847	915,691	16
17	Accumulated Depreciation (book methods)	(568,647)	(1,479,843)	17
18	Deferred Charges		72,737	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 105,017	\$ 1,325,390	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 280,148	\$ 2,315,303	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 8,861	\$ 66,428	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,873	134,111	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		50,496	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 38,734	\$ 251,035	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		915,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 915,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 38,734	\$ 1,166,035	46
47	TOTAL EQUITY (page 18, line 24)	\$ 241,414	\$ 1,149,268	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 280,148	\$ 2,315,303	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 90,891	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 90,891	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	110,157	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Related organization costs (Sch. VIII)	(36,705)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 73,452	17
	B. Transfers (Itemize):		
18	Streator Unlimited, Inc.	77,071	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 77,071	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 241,414	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Knox Estates

0024265

Report Period Beginning: 07/01/01

Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached**Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.**

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 660,148	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 660,148	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	2,021	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	920	15
16	Rental of Facility Space	858	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,799	23
D. Non-Operating Revenue			
24	Contributions	5,977	24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,977	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending & recycling	359	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 359	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 670,283	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	129,712	31
32	Health Care	295,086	32
33	General Administration	88,057	33
B. Capital Expense			
34	Ownership	9,643	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	37,628	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 560,126	40
41	Income before Income Taxes (line 30 minus line 40)**	110,157	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 110,157	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Exempt If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Knox Estates**

0024265

Report Period Beginning: 07/01/01

Ending:

06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing			\$	\$	1
2 Assistant Director of Nursing					2
3 Registered Nurses	597	746	13,129	17.60	3
4 Licensed Practical Nurses					4
5 Nurse Aides & Orderlies					5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides					8
9 Activity Director					9
10 Activity Assistants					10
11 Social Service Worker	196	199	2,221	11.16	11
12 Dietician					12
13 Food Service Supervisor					13
14 Head Cook	1,541	1,943	15,993	8.23	14
15 Cook Helpers/Assistants	2,462	2,701	22,971	8.50	15
16 Dishwashers					16
17 Maintenance Worker	431	472	6,042	12.80	17
18 Housekeepers	1,114	1,114	7,801	7.00	18
19 Laundry					19
20 Administrator					20
21 Assistant Administrator					21
22 Other Administrative					22
23 Office Manager					23
24 Clerical					24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)	994	1,227	21,612	17.61	28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)	17,233	19,597	191,788	9.79	30
31 Medical Records	1,746	2,080	29,123	14.00	31
32 Other Health Care(specify)					32
33 Other(specify)					33
34 TOTAL (lines 1 - 33)	26,314	30,079	\$ 310,680 *	\$ 10.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	43	\$ 2,379	1-3	35
36 Medical Director				36
37 Medical Records Consultant				37
38 Nurse Consultant				38
39 Pharmacist Consultant	9	450	10-3	39
40 Physical Therapy Consultant				40
41 Occupational Therapy Consultant				41
42 Respiratory Therapy Consultant				42
43 Speech Therapy Consultant	29	1,725	10a-3	43
44 Activity Consultant	9	495	11-3	44
45 Social Service Consultant	2	124	12-3	45
46 Other(specify) <u>Psychologist</u>	N/A	350	10a-3	46
47 <u>Computer consultant</u>	2	60	10-3	47
48				48
49 TOTAL (lines 35 - 48)	94	\$ 5,583		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$		50
51 Licensed Practical Nurses				51
52 Nurse Aides				52
53 TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries:				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
				\$	Workers' Compensation Insurance		\$ 11,849	IDPH License Fee	\$		
					Unemployment Compensation Insurance		543	Advertising: Employee Recruitment		121	
					FICA Taxes		23,400	Health Care Worker Background Check			
					Employee Health Insurance		42,436	(Indicate # of checks performed _____)			
					Employee Meals			NHA license		100	
					Illinois Municipal Retirement Fund (IMRF)*			Subscriptions-Care facility resource		647	
					Retirement contribution		3,153				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$							
B. Administrative - Other											
Description				Amount							
				\$							
TOTAL (agree to Schedule V, line 17, col. 3)				\$							
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount		Description	Line #	Amount	Description		Amount	
Mason & Associates	Accounting fees		\$ 1,290				\$	Out-of-State Travel	\$		
TOTAL (agree to Schedule V, line 19, column 3)											
(If total legal fees exceed \$2500 attach copy of invoices.)				\$ 1,290							

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Knox Estates

0024265

Report Period Beginning: 07/01/01

Ending: 06/30/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. _____ Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease _____
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 37,628
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? NO If YES, attach an explanation of the allocation _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation _____
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such program during this reporting period. _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period \$ 7,373
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Mason & Associates The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____

XIX. SUPPORT SCHEDULES
G. Schedule of Travel and Seminar Attachment

SEMINAR AND TRAINING EXPENSES

<u>DATE</u>	<u>INDIVIDUAL</u>	<u>TITLE</u>	<u>SEMINAR TITLE</u>	<u>LOCATION</u>	<u>SPONSOR</u>	<u>COST</u>
6/29/01-8/15/01	J Arndt	Rec Therapist	QMRP Training	Aurora	DHS	101.71
7/31/2001	Karen Crabtree	RN & QMRP	Person Centered Care Plan	Rockford	ICAN	74.18
9/5/2001	Karen Crabtree	RN & QMRP	CPR	Streator	St. Mary's Hospital	30.00
10/9/2001	Various		Hum Rights/Abuse & Neglect	on-site	SU	2.74
10/30/2001	J Cashmer	DSP	CPR	Ottawa	Friendship Facilities	25.00
10/30/2001	J Cashmer	DSP	CPR	Ottawa	Friendship Facilities	10.35
11/8/2001	J Cashmer	DSP	First Aid	Streator	American Red Cross	7.00
11/9/2001	D Burns	Home Mgr	Grief/Loss for Persons/DD	Utica	Community Education	80.00
11/9/2001	D Burns	Home Mgr	Grief/Loss for Persons/DD	Utica	Community Education	24.15
11/20/2001	D Burns	Home Mgr	Survey Savvy	Princeton	IDPH	41.40
11/28/2001	J Cashmer	DSP	CPI	on-site	SU	7.24
11/28/2001	K Graham	CIS	CPI	on-site	SU	7.24
12/5/2001	K Graham	CIS	CPR	Streator	St Mary's Hospital	30.00

XIX. SUPPORT SCHEDULES
G. Schedule of Travel and Seminar Attachment

SEMINAR AND TRAINING EXPENSES

<u>DATE</u>	<u>INDIVIDUAL</u>	<u>TITLE</u>	<u>SEMINAR TITLE</u>	<u>LOCATION</u>	<u>SPONSOR</u>	<u>COST</u>
1/25/2002	J Carstens	QMRP	Nursing Home Administrator	Chicago	Continental Testing	443.85
2/28/2002	D Burns	Home Mgr	First Aid	Streator	American Red Cross	7.00
2/28/2002	A Burns	DSP	First Aid	Streator	American Red Cross	7.00
3/5/2002	M Klachko	Maintenance	Vehicle Grant Seminar	Springfield	IDOT	19.27
3/12/2002	J Carstens	QMRP	Nursing Home Administrator	Chicago	NHA	25.55
3/18/2002	J Barons	DSP	First Aid	Streator	American Red Cross	7.00
4/6/2002	M Klachko	Maintenance	Driving Training	Springfield	IDOT	14.35
4/19/2002	Karen Crabtree	RN & QMRP	Psych & Med/Down Syndrome	Peoria	Community Educ.	50.00
4/29/2002	J Carstens	QMRP	Nursing Home Administrator	Chicago	NHA	143.08
5/10/2002	A Burns	DSP	36 Hour Activity Workshop	Washington	VSA Illinois	325.00
5/20/2002	D Burns	Home Mgr	Handling People w/Diplomacy	Chicago	American Mgmt	169.00
6/14/2002	M Klachko	Maintenance	Passengers' Assistance	Bartlett	IDOT	13.65
6/20/2002	Various		CPI	on-site	SU	10.67
TOTAL						1676.43

KNOX ESTATES

#0024265

BEGINNING: 7/1/01

ENDING: 6/30/02

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XIX.

SUPPORT SCHEDULES

G. Schedule of Travel and Seminar Attachment

SEMINAR AND TRAINING EXPENSES

<u>DATE</u>	<u>INDIVIDUAL</u>	<u>TITLE</u>	SEMINAR <u>TITLE</u>	<u>LOCATION</u>	<u>SPONSOR</u>	<u>COST</u>
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